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ABSTRACT

This monograph, the first in a series of five, provides training information for hospice staff in improving interdisciplinary team functions and humanistic care provisions. Its purpose is to assist hospice directors, educators, and other administrative staff members to understand the focus of the proposed training and its applicability to their hospice. Chapter 1 describes interdisciplinary teams, team functions, the provisions of humanistic patient care, and training benefits. Chapter 2 lists prerequisites for training hospice staff, assists them in evaluating their training needs, and describes the environment needed for the training to be successful. Recruitment and selection of trainers is the focus of chapter 3. Criteria for selection, sources of qualified trainers, selection procedures, and operational considerations are detailed. Chapter 4 discusses the training program structure (length, frequency and timing of training sessions) and the selection of training program participants. Chapter 5 summarizes the responsibilities of the hospice administration and suggests some solutions to problems encountered in hospice training. An appendix contains the tables of contents of the five monographs. (YLB)

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ELM Institute

THE ELM INSTITUTE

GUIDE FOR HOSPICES

Monograph 1 in a Series:

INTERDISCIPLINARY TEAM TRAINING AND

HUMANISTIC PATIENT CARE

FOR HOSPICES

September 1981

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
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MONOGRAPH I

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FOREWORD

The ELM Institute is a not for profit corporation, founded to conduct research and education in established and emerging areas of health care delivery and policy. From the outset, one of the Institute's three major areas of interest has been terminal care, the others being cancer care and long term care of the impaired elderly.

While terminal care must function in the established health care delivery arena, its goals are substantially different. Instead of cure and rehabilitation, it acknowledges death and seeks to assure physical, spiritual, emotional and social comfort. We reasoned that this type of dichotomy would present organizational, structural, economic, and personnel difficulties as these two approaches were merged. These issues and their management are primary areas of interest to Institute staff.

For these reasons the Institute was pleased to receive the DHHS award to study the interdisciplinary team training and humanistic care training needs of terminal care programs. I believe the results contained in these volumes confirm our mutual judgment that alternative modes of health care delivery require unique staff interactions and support mechanisms in order to survive and meld with the current care system. Further, I believe you will find that the concepts utilized in this model for training and team development have broader programmatic applications than terminal care.

The Institute will continue to test and refine the model, and is willing to work with those programs who require specialized expertise or who face unique circumstances. In many other cases, it is our hope that these modules will provide sufficient information to an informed and experienced process consultant.

From the Institute's perspective, we intend to continue similiar research and development projects in health care delivery and in policy formulation. We are pleased to have had an excellent opportunity to further our investigations and to work with an excellent group of advisors and collaborators.

Lee E. Mortenson
President
ELM Institute
Rockville, Maryland
August, 1981

PREFACE

Purpose of the Series

The purpose of this series of monographs is to assist hospices in improving their quality of care, through enabling them to improve their ability to meet the needs of their patients and families. Objectives include: improving the functioning of the interdisciplinary team, integrating the patient and family into the team, ensuring the appropriate utilization of professional services, and improving staff awareness and capability of providing humanistic patient care. These objectives may be attained through a training program for hospice staff described in the monographs.

The goals and objectives of the training program relate directly to those of hospices. Both direct attention to the whole person - patient, family member, or staff member - individually and as a group member. Both attempt to integrate the physical, psychosocial and spiritual approaches to care. Both combine scientific knowledge, skills, affective awareness, and interdependent coordination of activity to achieve an orientation to comfort and growth for all those involved. Hospices, having already made significant progress toward their goals, can expect the training program to enable them to approach these goals more quickly, more comfortably, and more effectively.

Hospice staff members need to be highly skilled in both the technical and the humanistic aspects of health care. These monographs acknowledge the need for high quality professional skill on the part of all staff members but do not address it. Training information in this aspect is assumed to be already in place. This series of monographs was developed to fill an acknowledged gap in training information for hospices, that is, training information in improving team function and humanistic care provision.

The monographs provide a significant contribution to these hospice activities. They provide factual information, approaches, and methods for qualified trainers to utilize their existing knowledge and skills successfully in the unique environment of the North American hospice. The series is intended primarily for the use of trainers assisting hospices, and not as a self-

help guide for hospices; however, all or parts of the series may be a helpful resource not only to hospices and hospice trainers but also to others concerned with the interdisciplinary and humanistic qualities of hospice care.

These monographs are working documents. The information they provide has been developed by trainers who are leaders in the field, tested in two demonstration hospices, and then modified on the basis of these tests. The developers anticipate that additions and variations will be appropriate over time and through continuing use of the document.*

Review of the Series

This series of five monographs was written by the ELM Institute under the general title: Interdisciplinary Team Training and Humanistic Patient Care for Hospices. The monographs, outlined below, address the following topics:

Monograph 1: Guide for Hospices
Monograph 2: Guide for Trainers
Monograph 3: Training Program Design
Monograph 4: Interdisciplinary Team Training: Content and Methodology
Monograph 5: Humanistic Patient Care Training: Content and Methodology

Monograph 1, Guide for Hospices, is directed to hospice administrators. It may, however, be of interest to trainers and others. It describes teams, team function and the provision of humanistic patient care, and assists hospices to determine whether or not they have reached the state of development needed for this training. It identifies the objectives of the training and the anticipated benefits to the hospice, as well as the role of the hospice administration in the training and its financial and other obligations. In particular, it assists hospices to recruit and select one or more qualified trainers from outside the hospice organization to conduct the training. It also supplies useful suggestions to hospices based on ELM's hospice training experience.

Monograph 2, Guide for Trainers, is directed to "outside" trainers who may be invited by a hospice to conduct its training, although

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* Reports of experiences with the monographs and any recommended additions or modifications to them would be welcomed by the developers - the ELM Institute, 11600 Nebel St., Rockville, Maryland, 20852 - for inclusion in future revised editions.

it may be of interest to others, as well. It is recommended that all trainers anticipating work in hospices read this monograph, regardless of their prior experience, in order to learn more about the unique features of a hospice and the implications of training in the hospice setting. The document provides background information about the hospice concept, models, components, standards, and staff characteristics. It also assists trainers to determine whether or not the hospice and the trainer match sufficiently well for the training to be successful, and to recommend the appropriate staff members to be trained. The role of the trainer is reviewed and suggestions from ELM's hospice training experience are offered.

Monograph 3, Training Program Design, is directed primarily to the trainer(s) who has contracted with the hospice to conduct the training. It will also be useful to hospices in working with the trainer in developing their programs. It may also be of value to others. The monograph provides a detailed statement of goals and objectives of the training, and describes the steps of the training design: orientation of staff, initial data collection, identification of issues specific to the hospice concerned, preparation of reports, feedback of the reports to the staff, confirmation and prioritization of issues, and joint staff/trainer selection, design and planning of a customized training program to address these issues. Again, examples from hospice training experience are reported.

Monograph 4, Interdisciplinary Team Training: Content and Methodology, is again directed to the trainer, although it may also be of interest to hospices and others. It contains the materials needed to conduct the training, and includes examples of issues and approaches to interdisciplinary team training in the hospice setting. It is not intended to limit the trainer but to assist by providing hospice information, outlines of successful training sessions, examples from hospice training experience, and relevant literature resources. It contains checklists and hints that may be useful to trainers, particularly in their first hospice training experiences. The monograph is divided into four sections, covering the major interdisciplinary team training categories: goals, roles, structure, and procedures.

Monograph 5, Humanistic Patient Care Training: Content and Methodology, provides trainers with information concerning humanistic patient care training in hospices and is similar in structure to that in Monograph 4. Again, although directed to the trainer, it may also contribute to understanding by hospices and others of the humanistic approach and what training in humanistic patient care entails. The document provides examples from hospice experience in humanistic values and orientations, in issues relevant to training, and in humanistic training in hospices. There are sections on background information, checklists and hints for trainers, and outlines of successful training sessions. Pertinent references to the literature are included. The monograph addresses the definition of humanistic patient care and the topics: psychosocial variables in working with dying patients; patient and family needs, environment and

rights; patient/staff relationships, including listening and stress management techniques; staff/staff relationships and staff relationships with other health professionals, including listening and communication skills; and monitoring of humanistic patient care provision.

It is not essential for hospices or trainers to acquire the complete series. Each monograph was prepared to address a different audience and to be complete in itself. This approach however, necessitated the inclusion in more than one monograph of certain sections common to more than one audience or title. The reader of the entire series will be well aware of these repetitions.

Review of the Project

This series of monographs was developed by the ELM Institute under a two-year contract with Health Resources Administration, Department of Health and Human Services, entitled: "Assessment of Staffing Patterns and Development of Interdisciplinary Team Training and Humanistic Patient Care in Hospices". The contractor was the ELM Institute, with David J. English, D.B.A., its Executive Director, the project director and Dottie C. Wilson, its Hospice Group Director, the associate project director.

A Panel of Consultants was named to provide technical assistance and to assist in the development of a training program plan and an evaluation plan. Some members of the panel conducted hospice training sessions. An Ad Hoc Review Committee was named, representing major health care associations and approaches, to provide a broad perspective to the work undertaken and to assess its applicability to the health care system.

An analysis was performed of documents describing the organization and staffing patterns, including staff characteristics, in current U.S. hospices. The documents analyzed were the more than 250 applications by hospices to the Health Care Financing Administration for waivers of certain reimbursement regulations. This analysis, along with bibliographies and assessments of the anticipated impact of training on hospices, was published in July 1980 in a report entitled: An Assessment of the Existing Staffing Patterns and Personnel Required in a Hospice to Deliver Interdisciplinary Patient Care and the Problems Related to Delivering Humanistic Care to Hospice Patients.

ELM staff and Panel of Consultant members developed a training program plan, a statement of training goals and objectives, and, with the subcontractor, an evaluation plan. To test the plan, training was conducted in two demonstration hospices,

one an independent home care program and the other an inpatient and home care program within a hospital. The training was conducted by certain members of the panel of consultants with ELM coordination. Those trained included steering committees, a management team and patient care teams. The training was evaluated by the ELM Institute's subcontractor, Perry Cohen Associates, using both impact and process evaluation techniques.

Acknowledgements

The smooth conduct of the HRA contract and the significance of its results have been made possible by the availability and assistance of the HRA Project Officer, Mr. Thomas Aschenbrener. ELM appreciates very much his contribution to the success of the project and to the series of monographs.

All those who contributed to the project and to the series of monographs are listed in the Appendix to this volume. ELM extends sincere thanks to each of them, and in particular acknowledges the significant contributions of John A. Hackley, M.S.W., Mark S. Plovnick, Ph.D., Charles Seashore, Ph.D., and Terence F. VanOrshoven, Ph.D., to the development of the monographs.

The success of the training program demonstrations was in large part due to the enthusiasm, cooperation and support of the leadership of the two hospices concerned. Special thanks are due to Anne Kirschner Katterhagen, R.N., B.S.N., Executive Director of Hospice of Tacoma, Tacoma, Washington, and both Maryanne Fello, R.N., Director of Hospice Care, and Madalon Amenta, Dr.P.H., Director of Research and Education, Forbes Hospice, Pittsburgh, Pennsylvania, for their interest and assistance in the training demonstrations.

The ELM staff, including senior associates, research associates, and support staff, have been most helpful throughout the project and monograph preparation. We appreciate it.

David J. English, D.B.A., Project Director, and Dottie C. Wilson, Associate Project Director.

September 1981

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CHAPTER I

INTRODUCTION

A. PURPOSE OF THE GUIDE

This Guide for Hospices is intended to assist hospice directors, educators and other administrative staff members in understanding the focus of the proposed training and its applicability to their hospice. Should the training appear to be appropriate and timely for a hospice, the Guide outlines the responsibilities of the hospice administration in the training and provides guidelines in the recruitment and selection of trainers to conduct the training.

The proposed training is described throughout this series of monographs as being in two sections: interdisciplinary team training and humanistic patient care training. Each of these again addresses a number of aspects. Interdisciplinary team training addresses: the organization and the environment in which teams perform their tasks, the internal functioning of the teams themselves, and the relationship of team function to both task performance and the organizational environment. Humanistic patient care training, too, is concerned with the communication and interpersonal relationships between team members and between the team and its broader organization, but emphasizes the performance of tasks by teams or individuals. It, therefore, includes staff understanding of the needs, rights and interrelationships of patients and families, as well as staff/patient and staff/family communication.

Both interdisciplinary team training and humanistic patient care training address task performance and goal accomplishment in meeting patient and family needs, as well as the acquisition of knowledge, understanding, skills and techniques to this end. Clearly both are inexorably interrelated and interdependent, and need to be considered as part of the same process.

B. INTERDISCIPLINARY TEAM AND HUMANISTIC CARE DEFINITIONS

Meeting the needs of terminally ill patients and their families requires an interdisciplinary and humanistic approach to care. "Meeting needs" infers that the patients/families communicate their needs, directly or indirectly, and that the staff members understand the communication. Staff members also independently recognize patient and family needs and can help them to acknowledge unrecognized yet real needs. The staff then makes every effort to find approaches to meeting the needs.

The patient is recognized as a person with decision making, planning, care delivering and evaluating powers. The family is viewed in the same way. Both patient and family understand their rights and realize that they are in control. They also recognize that they are capable of personal growth through the dying experience. Humanistic patient care is this approach by staff to patients and families. It includes state-of-the-art professional physical care and psychosocial and spiritual support of patients and families as they maintain their independence and their preferred way of life and death.

As the needs of terminally ill patients and their families may be in multiple areas, multiple skills and disciplines must be utilized in any attempt to meet them. The approach, then, must be multidisciplinary. As these needs overlap for the patients and families, and as the solutions to some needs may conflict with solutions to other needs of the same patient and/or family, an interdisciplinary approach is needed. As no one person or profession can meet all the needs, and as no one person can successfully cope alone with the stresses inherent in this work, a team approach is indicated. The patient and family participate as team members. An interdisciplinary team, providing input into assessment, decision making, care and evaluation, with blurring of traditional roles and mutual information sharing and support, has been found to be a most effective approach to terminal care.

1. Interdisciplinary Team

Team activity is not confined to health care nor to any one specific structure. There are board member teams and management teams, as well as staff teams. Teams may have consistent membership or may have rotating members; teams may work together with frequent team meetings, or they may seldom meet face to face. They may be made up of members of one profession or discipline, or may include more than one profession or a mixture of professions and disciplines. An interdisciplinary team has been defined

by Ducanis and Golin* as "a functioning unit, composed of individuals with varied and specialized training, who coordinate their activities to provide services to a client or group of clients". Rubin, Plovnick and Fry** add that coordinating activities requires teamwork. "This need for coordination and working together is called 'interdependence'. Any job that cannot be done by just one person requires some degree of interdependence." (Hospice interdisciplinary teams are discussed at greater length in Monographs 2 and 3.) The Health Resources Administration has defined an interdisciplinary health team as follows:

> INTERDISCIPLINARY HEALTH TEAM is composed of three or more health professionals, including physicians and physician's assistance or nurses, who relate on an equal non-hierarchial basis to each other in the provision of health services to primary, secondary and tertiary care patients. Usually such teams have received didactic and experiential training concerning the roles of other health professionals, interpersonal communications, small group process, other organizational development concepts, and patient/provider relationships. The patient and the patient's family are considered members of the interdisciplinary health team, along with the physician and such staff as physician's assistants, nurses, aides, physical and occupational therapists, pharmacists, clergy, social workers, psychologists, administrators and volunteers as appropriate.***

2. Humanistic Care

The term humanistic patient care describes an activity that evades clear definition. In hospices, it has been defined by the humanistic training consultants of this project as a timely comfort-oriented focus for patient care and family care delivery. The term indicates an increased emphasis on the non-scientific elements of professional patient care (without reducing emphasis on the scientific elements).

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* Ducanis, A.J. and Golin, A.K., The Interdisciplinary Health Care Team, Germantown, Maryland, Aspen Systems Corporation, 1979, page 3.

** Rubin, I.M., Plovnick, M.S., and Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Co., 1975, page 3.

*** Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

The Health Resources Administration has defined humanistic patient care by reference to a definition of humanistic medicine:

> HUMANISTIC MEDICINE is medical practice and culture which respects and incorporates the concepts that: the patient is more than his disease, the professional more than a scientifically trained mind using technical skills, both are whole human beings interacting in the healing effort, a person is more than his body, he is a unique, interdependent relationship of body, mind, emotions, culture and spirit; each person has the capacity to define and be increasingly responsible for himself, the professional seeks to assist the patient in taking and fulfilling his responsibility for himself; health and disease are not matters of the moment but have intricate past, present and future; disease, physical, emotional or spiritual pain and suffering, aging and death are meaningful events in an individual's life; and effective health care requires not just conventional skills but also effective development and use of human qualities such as intuition, inventiveness and sympathy.*

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* Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

C. ANTICIPATED TRAINING BENEFITS

The growth of the team as a more cohesive and efficient functioning unit providing improved patient/family care is almost by definition a hospice goal. Interdisciplinary team training and humanistic patient care training contribute significantly to this goal. Hospices can anticipate the benefits of each to include the following:

1. Interdisciplinary Team Training Benefits

- Improvement in management team cohesiveness.
- Improvement in patient care team cohesiveness and communication for improved task completion.
- Greater acceptance of non-health-care-providers as full team members, that is, the patient, family, and lay volunteers, with resulting increased appropriateness of care.
- Improvement in the availability of care through the development of interchangeability of team members, each of whom operates under the same principles of care and knows each patient's and family's special problems and preferences.
- Reduction in staff stress and staff turnover through the provision of meaningful support to individual staff members by the more cohesive team.
- Improved efficiency and effectiveness within the hospice through improved communication between teams, such as between home care and inpatient teams, or between management and patient care teams.

2. Humanistic Patient Care Training Benefits

- Improvement in understanding by staff members of themselves and their effect on patients and families, with resulting improvement in staff relationships with patients and families and reduction of staff stress.
- Improvement in interpersonal relationships and communication within the team and between team members and other caregivers.
- Improvement in the ability of staff to recognize and deal with psychosocial and spiritual problems, family dynamics, and environmental problems, and to do so in a more efficient and timely manner.

- Improvement in pain and symptom management through improvement in meeting interrelated psychosocial and spiritual needs.

- Improvement of skills in listening and feedback.

- Increased understanding of patients' rights, particularly their rights to determine their own care and to maintain their own personal lifestyle.

- Improvement in staff recognition of cultural, religious/spiritual and environmental influences on patients and families, and staff ability to adapt to these factors and take them into account in care planning and provision.

To gain benefits such as these, the training needs to be both appropriate and timely. Before proceeding, therefore, the hospice should assess its needs for the training and its ability to provide the environment needed for the training to be successful. These topics are addressed in the next chapter.

CHAPTER II. PREREQUISITES FOR TRAINING

The benefits of interdisciplinary team training and humanistic patient care training can accrue only when certain prerequisites are satisfied. Hospices can recognize their readiness for this training by the degree to which they can answer the following questions in the affirmative. (Each of the prerequisites is discussed later in this chapter.)

- Are the significant problems faced by the hospice during its planning and development now resolved?
- Is the hospice providing care and is it in a stable organizational environment?
- Is the hospice economically stable, expected to continue in operation in the foreseeable future, and capable of making the financial commitments necessary for the training?
- Is the organizational structure of the hospice reasonably well established; are job descriptions of some or all of the staff clearly stated?
- Is the hospice administration willing to look at its organization and consider modifying it, should operational problems be found that would be detrimental to the attainment of the training goals?
- Is the patient care staff of the hospice already competent in providing professional skills and a caring approach to its patients and their families?
- Does the hospice provide orientation for new staff and regular ongoing inservice education for all patient care staff?
- Is the size of the hospice and its staffing pattern consistent with team function?
- Is the hospice dedicated to a team approach to patient and family care?
- Is the Board of Trustees (for independent hospices) or the institutional management (for dependent hospices) not only committed to hospice, its continuation and growth, but also interested in improving staff performance in providing high quality care?
- Is there an expressed need for this kind of training as identified by both the hospice administraion and the patient care staff members? (Has this need been identified also, directly or indirectly, by patients or families?)

- Is there sufficient time and energy for the appropriate staff to participate in the training?

- Can an individual be identified to whom a trainer* can relate as the trainer's "client"?

- Is there an attitude conducive to new ideas and change?

To clarify these questions and explain their importance to the training program, each is discussed below, under the following headings:

- Resolution of Developmental Problems,
- Operational and Economic Stability,
- Viability of the Formal Organization,
- Competency of Staff,
- Existence of a Team, or Teams,
- Hospice climate for Training.

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* For purposes of this series of monographs, "trainer" means the formal leader of the training program sessions, as well as the person conducting the data collection, data analysis, and training program design. This term is used throughout, even though the training is directed more toward staff development than teaching technical knowledge and skills. As it is recommended that the trainer(s) be found outside the hospice setting, the trainer is acting much like a consultant physician does in patient care. The term trainer is used, therefore, in lieu of the terms consultant, facilitator, process person, change agent, O.D. specialist, or leader.

A. Resolution of Developmental Problems

Organizational problems faced by hospice programs can exacerbate staff stress and inhibit humanistic patient care. These problems may be developmental problems, operational problems, or both. Hospice initiators, in the process of organizing hospice programs, are faced with developmental problems in the planning, structure, financing, and initial operationalization of the program. Operational problems (addressed in the next section) arise once the program is underway, in the day to day performance of tasks to carry out the missions and functions of the organization. Some operational problems are associated with unresolved developmental problems.

Hospice programs are ready for interdisciplinary team training and humanistic patient care training when their developmental problems are resolved or resolvable.

To clarify the term "developmental problems" further, specific examples of such problems that have been encountered in North American hospice programs are cited, as follows:

- One program floundered for two years because its founders wished a freestanding hospice program, whereas the medical community wanted a hospital-based program. The disappointed founders shifted their program development to a hospital-based program.

- Another operated for almost two years without receiving any dollars for hospice care (having no skills in writing grants or finding funding sources) which resulted in significant staff stress and turnover. This program then succeeded financially because of the volunteer help of an individual who understood fund raising and community planning.

- One hospice group applied seven times for a Certificate of Need for home care (required by state law) and failed. Without it there was no likelihood of reimbursement in that state.

- A home care hospice program, whose major source of referral was a large teaching hospital, was almost destroyed when the teaching hospital decided to develop its own hospice program.

- One hospice board split into factions when one of the original founders, nationally known, was asked to leave the program.

- A grass roots program failed totally when no attempt was made to enroll the medical community in the effort.

- Major staff stress was experienced in one hospice when its executive director, well liked by the staff, was fired for administrative incompetence.

- A hospital-based program had its organizational position shifted within the hospital structure five times in the first three years.

- Another hospital-based program opened with a flourish but closed again within two weeks following major staff discharges and transfers by the hospital administration because of low hospice unit occupancy. The hospice initiators had clearly misrepresented normal start-up procedures and had failed to recnogize the necessary agreements with the institution's management before opening. A year's care was lost until a second, more educated attempt proved successful.

Clearly, such developmental problems, if still being faced by operating hospices, will continue to affect both administrative and patient care staff to the detriment of patient care quality. The training does not deal with these problems and should be introduced only when they can be resolved by the hospice management and administration.

B. Operational and Economic Stability

As mentioned above, operational problems may also have a negative impact on training if these problems are due to the continued existence of unresolved developmental problems or their aftermath. However, most other operational problems may be properly addressed in the training.

Assuming that the hospice is providing care and is sufficiently economically viable to be expected to continue to do so, it is appropriate for the hospice administration to consider the training seriously and to address its financial implications. Costs are involved both in the initial, trainer conducted training and in the ongoing training. Compensating factors also should be considered (ie. training expenses are partially reimbursable).

1. Costs of Initial Training

The training entails both direct and hidden costs. These costs include:

- Fees to trainer, and, where applicable, the trainer's travel and living expenses.

- Equipment and materials for training, such as flip-chart or blackboard, photocopies of written materials, forms, reprints, etc. and perhaps rental of films, tapes, projector and screen.

- Space for the training, if there is a charge for the room, or if the room would be utilized otherwise if if were not being used for training.

- Duplication of the above costs if training sessions are repeated for staff working on different shifts.

- Salaries of staff participating in the training. If salaries are regularly paid based on reimbursable activities, training time may need to be paid time without reimbursement. In addition, overtime or additional staff may need to be paid to perform the reimbursable activities not undertaken by the staff while participating in the training session.

- Salaries of staff arranging for the training, if they, by doing so, do not perform other needed functions, or if other costs are incurred in the performance of these needed functions by others or in overtime.

- Possibly, the fees and expenses for staff members to attend training sessions or conferences in other locations, if recommended by the trainer and agreed to by the hospice.

The length of the training time overall, and the length of each training session will affect the total cost of the training program. As the training concerns beliefs, values, relationships and skills, it is realistic to assume that training will cover a considerable period of time for the training to have a major impact on team effectiveness and the patterns of care delivery.

2. Costs of Ongoing Training

The training in both interdisciplinary team and humanistic patient care includes two parts: the more formal program addressed in this series of monographs which is conducted by a trainer and requires regular, frequent training sessions, and ongoing reassessment and training developed by the staff without trainer assistance. This ongoing aspect of the training is essential to the continuing positive effect of the initial training and is emphasized throughout the initial training, as described in Monographs 4 and 5.

The costs of the ongoing training include all those itemized for the initial training except for the costs of the trainer. Staff costs, however, are reduced as sessions are held for shorter time periods and less frequently; in fact, the ongoing sessions may be incorporated into existing staff meetings. However, the hospice administration would be well advised to assume that some costs will be entailed in the ongoing aspects of the training.

3. Continuing Education Credits

A compensating factor for the training costs is the probability that the hospice administration can obtain approval for continuing education credits for the staff members participating in the initial training sessions, particularly for nursing staff. The obligations of the hospice in this regard include:

- Completion of application forms, development (frequently with the assistance of the trainer) of a list of training objectives, and submission of these to the accrediting agency.

- Supervision of the documentation by staff of the accomplishment of the stated objectives, maintenance of these documents on file for the time period prescribed by the accrediting agency, and assurance of access by the agency to the documents when requested.

With experience, and with the assistance of the trainer or trainers, the benefits of continuing education credits far outweigh the burden involved in obtaining them.

C. Viability of the Formal Organization

The formal organization of a hospice - and the individuals filling the designated positions - may reflect unresolved developmental problems. For example, from ELM's hospice experience:

- The hospice director in a hospital may report to a particular department head because the department head sponsored the hospice and the hospice unit beds are located in that department.

- The person in charge may not be adept in staff supervision or team leadership but may not be considered replaceable because he or she was the original initiator of the hospice.

- The patient care staff may be unsuitable to the work but feel secure because of personal friendships with the hospice director.

- The initiator of the hospice may have no line authority but may impose his or her will on the program indirectly.

To remedy such situations before the training begins, it may be necessary for the hospice to negotiate the withdrawal of the initiators and their friends and to structure the hospice to comply with more realistic needs, such as reimbursement regulations, referrals, autonomy and patient care.

Formal organization problems that are not developmental may be addressed before or during the training. These problems may include (based on ELM's hospice experience):

- Allocation of decision making authority between the hospice administration and the team.
- The number, frequency and length of meetings for which staff are paid.
- The dilemma of staff members reporting to two "masters" - either reporting to both the executive director and the medical director of an independent hospice, or, in a dependent hospice, reporting to both the institution's department head of their discipline and the hospice management.
- The regulations concerning home care staff visiting patients in hospital.
- The formal job descriptions of staff in relation to staff members' established team roles.
- The allocation of formal medical responsibility for patient care between the patient's primary physician and the hospice medical director.
- The criteria for employment of patient care staff members in terms of emphasis on being professionally skilled or being team players.

D. Competency of Staff

The training program assumes that:

- Participating staff members are skilled in their professions,
- They have received training to adapt their professional training to hospice patient needs,
- They care about, as well as care for, their patients, and
- They maintain their skills up-to-date through a regular inservice education program.

These assumptions are established both because the training does not address professional skill issues and because the training is less effective if staff competency itself is an issue.

E. Existence of a Team or Teams

A major portion of the training is devoted to team building. For this to be effective, the existence of a team (or teams) is clearly necessary. (Further discussion of teams may be found in Chapter IV.) Team function may be a problem for some hospices. For example:

- If the hospice is not team oriented, this part of the training may be inappropriate or ineffective. Since one of the standards of hospice care calls for a team approach, it is expected that most do operate in teams, with varying levels of success.

- If the hospice is small, the small number of staff members - particularly patient care staff members - may make effective interdisciplinary team function difficult regardless of training. Also, there may be too few disciplines represented, or the disciplines may be represented by individuals who allocate only a minute percentage of their time to hospice, and this time may include only attendance at patient care review meetings or only patient consultations.

- Alternatively, the entire staff may be large in number but all staff may be allocating only short periods of time to hospice work. This has been seen frequently both in hospices which are part of a large home health agency, and in independent home care programs during their first year of operation. In these hospices, it may be extremely difficult for all staff members ever to meet together for either team meetings or training sessions, because of conflicting time schedules.

F. Hospice Climate for Training

Interest and enthusiasm for training is needed for the training to proceed successfully. Evidence of this positive approach to the training is needed from the following groups:

- The hospice management. This includes the Board or the institutional management whose approval is needed for the financial commitment, if not for the activity itself. The degree of dedication of the management to high quality care has a major effect on the outcomes of the training.

- The hospice administration. The politics of the organization and/or a lack of enthusiastic support for the training may invalidate any training efforts. The hospice director is a key figure in the planning, design and implementation of the training and is the one who can have a significant effect on the outcome of the training program over time. From ELM's hospice training experience it appears clear that the hospice director should be "the client" for the trainer. If the director is not enthusiastic about the training and its potential, neither the training participants nor the trainer will receive the support they need for the training process.

- The staff members to be trained. The potential training participants need to see a need for improvement in the training topic areas and also to see the training as aimed at meeting this need. They also should be in a position to participate actively in the training: they need a place, time, energy and, in some situations, either a reduced workload or assistance from others in performing their regular duties.

- Patients and families. The training would appear to be particularly appropriate and necessary if indications have been received by the hospice administration from patients and/or their families that improvement is needed in the training topic areas.

All hospice personnel - management, administration and staff - should not only have an attitude that is open to change and to new ideas and approaches, but also should be willing to grow - to try new skills and relationships with both patients and peers. With this attitude, the training can have a major and lasting impact.

The impact of the training program is, in part, a function of the skill of the trainer. The hospice administration will benefit from the information in the next chapter when choosing a trainer for the program.

CHAPTER III. RECRUITMENT AND SELECTION OF TRAINERS

A hospice which recognizes the need for this training and which meets the prerequisites outlined in Chapter II is ready to find an appropriate trainer (or trainers) and begin the training program.

A. The "Outside" Trainer

It is important for the hospice to understand that the value of the training will be maximized if conducted by a skilled and knowledgeable individual outside the hospice, not by the hospice itself. There are several reasons for this:

- The group of training participants in most cases, includes both supervisors and the supervised, both professionals and non-professionals, and both paid and volunteer staff members. In this training session, this group works together to reach common goals, to identify roles, to determine procedures, to understand themselves better both individually and as group members, and to learn and practice new interpersonal skills. A facilitator/trainer to assist the group in working through these frequently sensitive areas needs to have both highly developed process skills and an independent, non-partisan, disinterested yet concerned approach. Rarely can such a facilitator/trainer be found within the hospice setting, in ELM hospice training experience. In ELM's view, a person outside the hospice (and outside the institution of which the hospice may be a part) is more likely to have the skills and approach needed for this hospice training,

- The training is more effective when the trainer acts as facilitator* only, not as both facilitator and participant at the same time,

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* The term "facilitator" is a derivative of the verb "to facilitate", which refers to "a process by which events are 'helped to happen'. Facilitating is a kind of influence role which is neither authoritarian, one the one hand, nor abdicative, on the other". (Vailly, P.B., "Informal Glossary of Terms and Phrases in Organization Development", in Jones, J.E. and Pfeiffer, J.W. (editors) The 1973 Annual Handbook for Group Facilitators, La Jolla, CA, University Associates, 1973, reprinted with permission in Weisbord, M.R., Organizational Diagnosis, A Workbook of Theory and Practice, Reading, MA, Addison-Wesley Publishing Company, 1978, page 73.)

- It is more comfortable for the participants to be open and to attempt new skills under the direction of an outsider than of a peer or immediate supervisor,

- The real issues facing the hospice and the team can be articulated in a less threatening manner by an objective outsider than by a group member,

- The new personality and new skills an outsider brings to the group increases the group's enthusiasm and openness to learning, and

- The group leadership skills to facilitate experiential and affective learning* which are needed for the training can be found in a qualified outside trainer. Few hospices or other health care provider organizations have on staff individuals with the process skills needed to conduct this training. Those staff members who do possess related skills may be important contributors to the ongoing training, once the formal training program is completed, and should be encouraged to improve their process skills by participating in the training program.

Hospices which are part of a larger organization may be tempted to utilize that organization's training personnel, for reasons of both convenience and economy. Care must be taken in such a decision, however:

- Such training personnel may not have the appropriate orientation for a team approach and the group process skills needed for this training. (Their special expertise may be utilized in some parts of the program as "alternate trainers".)

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* Experiential and affective learning are learning models employed in both interdisciplinary team training and humanistic patient care training. Experiential learning means learning through experiencing within the group, and then analyzing and generalizing from the experience. The experience may be actual or simulated (through role playing, or through video taping of group members' interactions). It refers to experiences presently taking place within the group sessions (not reporting of experiences that have taken place with others). Affective learning implies emotional learning (as in the heightening of awareness) rather than cognitive learning, and includes exploring and generalizing feelings. It may refer to either individual or group learning.

- These trainers may be well known to the hospice staff, may have led professional training sessions in the past, or may have acted as resources to the staff in technical matters. If so, they may be close enough to the group to create the same problems for staff as would an internal hospice trainer.

- The confidentiality of the activities within the training sessions which need to be assured might be difficult in such an institutional setting.

Ideally, therefore, the trainer should be a highly skilled person, who is completely outside the group and unknown to the participants.

B. Selection Characteristics and Qualifications

How does a hospice select a trainer? How can it avoid inappropriate, disruptive or ineffective use of its training dollars in contracting with an outside trainer?

A number of options are available to the hospice. It may chose one principal trainer to conduct the entire program or two principal trainers for the two sections of the program. It may also employ individual alternate trainers to conduct special topic areas (particularly in the humanistic patient care section) in which the principal trainer(s) have little competence. It is recommended however, that as few different trainers be utilized as possible, in order to maintain continuity and build rapport, while still providing the training leadership, skills and knowledge required.

Interdisciplinary team training requires a group or team approach rather than an individual development or Gestalt approach. The team trainer must be able to address both organizational and work group issues and must encourage group decision making and participant equality. Humanistic patient care training, which by definition explores both interpersonal and intrapersonal processes, requires a very skillful person. This person must maintain a "controlled" yet safe and honest environment for the group to deal with sensitive areas, while preventing the sessions from becoming sensitivity sessions or T-groups.

To assist the hospice in selecting a trainer or trainers, a set of criteria has been developed to identify one principal trainer for the entire training program, shown in Exhibit 1, following. This exhibit also identifies additional criteria for each section of the training. These criteria together include both the process skills required in the two sections of the training and the specialized trainer knowledge and skills unique to each section.

Exhibit 1

TRAINER CHARACTERISTICS

OVERALL KNOWLEDGE AND SKILL AREAS	SPECIAL KNOWLEDGE AND SKILL AREAS	
Interdisciplinary Team & Humanistic Patient Care	Interdisciplinary Team Training	Humanistic Patient Care Training
Substantial prior process experience with diverse human service groups (preferably to include health care personnel) Recent, and preferably on going experience with small groups Understanding and interest in mission of hospice and recognition of the variety of individuals involved Understanding of intent of training** Expertise in conflict management and problem solving* Understanding of role as change agent in training process Heightened awareness of own and others' feelings** Calm, accepting, self-reliant - capable of managing other resource persons** Ability to provide 3-5 references where process skills were employed	Expertise in organization analysis and development Knowledge of professional roles in health care Knowledge of interdisciplinary team theory Skills in information collection Skill in using a wide variety of team building techniques Knowledge of strategies for decision making Skill in resolving destructive interpersonal conflicts Ability to mold supervisors and the supervised into a cohesive group Awareness of techniques for program evaluation	Acceptance of prescribed boundaries for training (intent not to conduct indepth sensitivity sessions) Openness to multiple training approaches (not identified with one particular dogma) Understanding of theories in humanistic medicine, wholistic health, and hospice care Knowledge of psychosocial variables impacting dying Expertise in teaching communication skills Heightened awareness of intrapersonal and interpersonal dynamics Sensitivity to diverse cultures Knowledge and skills relating to stress management Understanding of patient rights

* of particular relevance in interdisciplinary team training
** of particular relevance in humanistic patient care training

C. SEARCH FOR QUALIFIED TRAINERS

Where does a hospice find qualified trainers? What are their professional titles?

In selecting trainers, equal consideration should be afforded both demonstrated process experience and academic credentials or certifications. Qualified trainers may be found among the following professional groups:

- Health care educators,
- Human relations training people,
- Organization development* consultants who have specialized in team building or health care,
- Consulting social psychologists,
- Psychiatrists,
- Other health care professionals (such as physicians, nurses, social workers, chaplains, or counselors) who have special process training and skills, and
- Humanistic medicine specialists.

These individuals may be recruited from a variety of community settings or referred by national organizations. Recruitment sources include:

- Universities or colleges (in particular, departments of continuing education, psychology, and management),
- Community health agencies/organizations involved in internal or community training (such as hospitals, nursing homes, community mental health centers, neighborhood health centers),

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* Organization development (O.D.) means "an evolving collection of philosophies, concepts, and techniques, which aims at the improvement of organization performance by intervening in social systems (the patterns of social relations existing within a formal organization). Attempted changes may be directed at individuals, dyads, groups, intergroups, formal structures, or cultures. O.D. is not yet a coherent applied science. It derives more from the social than the biological or physical sciences." (Vailly, P.B., "An Informal Glossary of Terms and Phrases in Organization Development", in Jones, J.E. and Pfeifier, J.W. (editors), The 1973 Annual Handbook for Group Facilitators, La Jolla, CA, University Associates, 1973, reprinted with permission in Weisbord, M.R., Organizational Diagnosis, A Workbook of Theory and Practice, Reading, MA, Addison-Wesley Publishing Co., 1978, page 75.)

- Municipal, county, state and federal health and social service departments, associations, and institutions,

- State and local chapters of national associations (e.g., American Hospital Association, American Medical Association, Oncology Nursing Society, American Cancer Society, United Way), and

- The Organization Development Network and/or the Registry of Organization Development Consultants.

D. Selection Procedures

Once the hospice has developed a list of potential trainers, the selection process begins.

1. Trainer Supplied Documentation

The hospice should obtain from prospective trainers the credentials or references to identify:

- Experience and demonstrated skill in conducting programs related to interdisciplinary team training and humanistic patient care training.

- Understanding and/or knowledge of and/or interest in:

  - The hospice philosophy,
  - Professional roles in health care
  - Constraints facing health care organizations such as regulations, financing, dependence on other community or organizational entities, and
  - Principles of humanistic health care.

- Motivation to work in a hospice setting, such as an interest in improving the quality and efficiency of patient/family care, based on personal experience with the critical illness of a friend or relative.

- Trustworthiness and professionalism in work situations, by providing references known and trusted by the hospice to track the trainer's past trustworthiness and professionalism.

2. Personal Assessment

The hospice should arrange an interview with each potential qualified trainer in order for the key management staff to have an opportunity to meet with and assess the trainer. Areas of assessment include:

- Ability to adapt

  Trainers for this work should be able and willing to modify or adapt their approaches or utilize new approaches that are consistent with the identified needs of the hospice.

  Appropriate trainers should be aware of differences and connections between individual professional development, small group development and organization development. They should also understand how these factors are likely to be interdependent in each specific hospice setting.

- Ability to collaborate

  Trainers should demonstrate willingness to collaborate with other resources identified by the hospice, and when appropriate, to work as part of a team in implementing the training.

- Willingness to accept client control

  Trainers should be willing to understand clearly who the person or group is to whom they report and relate (the "client") and develop clear contracts concerning the process to be followed and the financial, legal, and time obligations. Trainers should be willing to discuss any conflicts with the client.

Once the selection process is completed, the hospice and the selected trainer or trainer(s) can proceed with the training program design, described in Monograph 3. This important function of evaluation of the training and of the trainer are also described in Monograph 3.

E. Alternate Trainers

More often than not, a hospice will not find a single trainer who can conduct all sessions effectively in both interdisciplinary team training and humanistic patient care. Even when two trainers are identified, one for each, on occasion, other trainers may be needed to provide substantive information in content areas such as aging, illness and dying. The following sources are recommended in locating such alternate trainers:

- Social/human science educators in chronic/long term care specialties with competencies in the social and psychological aspects of aging, death and dying, and bereavement. Persons with these skills may include educators from the disciplines of social work, sociology, psychology, or anthropology.

- Health educators with both acute care and chronic care orientations. These individuals may be found in universities, colleges or junior colleges, public health departments, public or private acute care or long term care settings.

- Health care professionals (such as physicians and nurses) who have had special training and experience in process facilitation.

- Social workers, psychologists, human relations specialists who deal with health professional interpersonal relationships. These persons may be found in established private practice psychology groups, public institutions such as community mental health centers, other health provider programs, or colleges or universities.

- Religious and/or spiritual advisors. Persons with necessary skills may be found in non-denominational community counseling centers and in hospital pastoral care programs.

- Restorative care personnel (occupational/physical/recreational/speech therapists). These individuals may be found in medical schools, hospitals (physical medicine departments), visiting nurse associations, and in allied health professional programs on college campuses.

In addition, the principal trainer(s) may be in a position to recommend appropriate alternate trainers. Further discussion of alternate trainers may be found in Monograph 3, Chapter VI.

F. Operational Considerations

As has often been the case in ELM's hospice training experience, the hospice may find itself attempting unsuccessfully to coordinate people, time, and dollars. In such a situation, clear prioritization is difficult - but may be approached as follows:

- It is better to have the right trainer for each section of the training than to have one trainer for the entire program who is less appropriate.

- It is more important to have the right trainer than to begin training immediately, if the right trainer is unavailable for a time. However, two points should be mentioned:

  - the postponement should not be longer than a few months, and

- the data collection and training program design (Monograph 3) should not begin until the trainer is able to proceed with the training very soon thereafter.

- Within limits, it is better to adjust the routines of the hospice staff to meet the available day and time of a qualified trainer than to accept a less qualified trainer who can fit into the hospice schedule. However, it is essential that all hospice staff participants be able to attend at the time set for the training sessions.

- If possible, it is important to judge the degree of need or the severity of the existing staff problems in relation to the qualifications and fees of the trainers being selected:

  - The more highly qualified trainers frequently charge higher fees. Payment of such fees may be money well spent if resolution of the problem in the hospice require such qualifications. It is wiser to seek other sources of funding than less effective trainers.
  - The best trainers may not be located in the same community as the hospice (particularly for hospices located in small communities). It is better to find the funds to pay the travel expenses of the trainer than to accept an insufficiently qualified local trainer. (Compromises may be made in this case, such as holding two or more sessions on concurrent days to reduce the number of trips the trainer and therefore the total travelling expenses.)

- In situations where financial resources cannot be expanded, it is better to commit the resources available to fewer sessions with the right trainer than to hold the recommended number of sessions with a trainer who cannot adequately address the issues defined in the hospice setting.

Although postponements and adaptations may be necessary, a positive approach on the part of both the hospice and the trainer will tend to result in an appropriate training plan. Indeed, in the process of negotiation the hospice and the trainer will learn a great deal about how well they will be able to work together during the training.

The hospice administration needs to consider carefully with the trainer the structure of the training program and the personnel who should participate. This topic is discussed next.

CHAPTER IV. TRAINING PROGRAM ALTERNATIVES

There are no unalterable rules concerning the structure, length, frequency or timing of the training sessions nor the complement of staff to be trained. However, some comments and suggestions are presented, based on ELM's hospice training experience. (These comments are also included in Monograph 2, Guide for Trainers.)

A. Training Program Structure

Although this series of monographs assumes a training organization that has proved successful in the past, it leaves open to the trainer and the hospice a variety of alternatives:

- In the recommended program, the structure is made up as follows: interdisciplinary team training precedes humanistic patient care training, interdisciplinary team training opens with a session on goals, and humanistic patient care training opens with a session on definitions and applications, although within each of the two sections of the training program (Monographs 4 and 5), a number of alternatives in session organization or sequence are discussed. This overall structure is recommended for a number of reasons including the assumption of an increased comfort level on the part of the participants as the training proceeds so that participants are ready for each session as it occurs. However, in hospices where the comfort level of the group is already high and/or the staff's major concern is the humanistic patient care section, it may be wise to modify the recommended structural sequence. Similiarly, it may be possible for the two sections to be provided concurrently, or partially overlapped.

- The number and length of sessions in each section, described in Monographs 4 and 5, are based both on those needed in hospices where training has been conducted and on those recommended in the literature. Again, these may be modified. However, careful consideration needs to be given to this question by both the hospice and the trainer to ensure that a sufficient number of sessions of sufficient length are provided for the issues to be addressed and for the training process to be effective.

- The frequency of sessions is variable, and has not been consistent among those already trained. Sessions may be held weekly, twice a week, every two weeks, or full time for several days. The suggestions of the trainer may be helpful, particularly after the data collection activity, in planning the training schedule.

- The elapsed time between the interdisciplinary team training and the humanistic patient care training, if held sequentially, may vary from none to several months without apparent negative effects. It is postulated that a short period between the two allows the participants to integrate their new skills and approaches before beginning the next section.

B. Training Program Participants

The selection of participants in the training presents many alternatives. For example, the participants in each of the two sections need not be the same, and, in the interdisciplinary team training, more than one team may be trained, either separately or together.

1. Identification of Teams for Interdisciplinary Team Training

The many models and levels of development of hospices make it difficult to specify hospice teams clearly. The following differentiation may provide a useful general approach:

- Management Team. This term identifies the hospice administration, which may or may not operate as a management team, but which may develop into a management team through the training process. Membership usually includes the director, the administrator (if a different person), and the supervisors, usually including the medical director, nursing director (for all nursing or for each of inpatient and home care), social work and/or bereavement director, chaplaincy coordinator, volunteer coordinator, education coordinator, etc.

- Core Team. This team, most frequently found in smaller hospices, includes the management team plus those primarily responsible for patient care (usually the nurses). It may also include the hospice secretary.

- Patient Care Team or Teams. Depending on the size and number of components of the hospice, these teams may either be defined as the small groups which may change with each patient depending on that patient's needs or may be component teams, including all those participating in each component of care provided: home care, inpatient care (may be split into shift teams), and bereavement care. Membership in one or more patient care teams usually includes all patient care staff including those listed above plus aides, therapists, nutritionists, etc., but not the hospice director. Frequently, volunteers are represented by volunteer leaders for each component rather than all volunteers belonging. Similarly, clergy may be represented by the hospice chaplain coordinator or may all be included.

2. Designation of Interdisciplinary Team Training Participants

It is possible for all staff to participate in the training, in one group (if of manageable size) or in several groups. The group to be trained, however, should be a group which considers itself a team directed toward accomplishing a particular task which requires coordination of team members.

It also needs to include three or more disciplines for interdisciplinary team function in task performance. In addition, the group itself should be involved in determining its membership.

Factors which influence the choice of training participants include the following:

- Participation should be voluntary, with the condition that, once they agree, the participants will continue and attend all sessions.
- The objectives of the training, and the identification of training needs, help identify those who should participate.
- Scheduling of time (particularly inpatient shifts) may prevent some appropriate participation unless alternative care staff are supplied.
- Availability of funds for alternative care staff, and the level of reimbursement of regular paid staff for training time may limit the number or levels of staff able to participate.
- Choices may need to be made for large groups (such as volunteers) or rotating discipline representatives (such as chaplains or physicians).
- Special decisions may be required for individual problems, such as for particularly disruptive individuals, management favorites, staff members soon to resign, and those peripheral to the primary tasks of the team.

Although the hospice needs a clear view of the group or groups to be trained in order to proceed, it must also be open to modifications in the choice of participants if proposed by the trainer or if identified in the data collection.

3. Designation of Humanistic Patient Care Participants

While interdisciplinary team training clearly emphasizes team function and therefore requires team participation, humanistic patient care training may be enhanced by a more liberal interpretation of the patient care provider. All individuals who have direct contact with patients and their families, as well as those who supervise these individuals, may benefit from training in the humanistic approach. Although appropriate group size for effective training may limit those participating, and although the same factors of time and funding affect this as well as team training, consideration should be given to include the following personnel in humanistic patient care training:

- Patient care staff (physicians, nurses, aides, home-makers, social workers, therapists, chaplains, nutritionists, etc.),
- Hospice secretarial staff and insurance/accounting staff who have direct contact with patients and families, if only by telephone,
- Administration, whose administrative and fiscal duties are affected by the humanistic approach to patients and families,
- Local clergy, and
- Volunteers, particularly those participating regularly and frequently in patient care.

Again, the recommendations of the trainer will have a major influence on the choice of humanistic patient care training participants and the size of the group to be trained. The trainer may also be in a position to advise concerning the implications of changes in participants between the two training sections for the particular hospice concerned.

Even though the hospice administration has agreed to the training and contracted with a trainer, its work is not yet done. Its further responsibilities are described in the next chapter.

CHAPTER V. ROLE OF THE HOSPICE ADMINISTRATION IN THE TRAINING PROGRAM

Clearly, the hospice administration plays an important role before, during and after the formal training program takes place. This chapter attempts to summarize the responsibilities of the hospice administration and to provide some suggestions based on ELM's hospice training experience and the recommendations of experienced trainers. To repeat an item discussed in the chapter on training prerequisites, the enthusiastic support of the hospice administration is key to the success of the program and to the realization of the anticipated benefits.

A. Hospice Administration Responsibilities

The hospice administration should be prepared to assume the following responsibilities and obligations for the training:

- Consider the training program as a joint planning effort with the trainer, and contribute to its development.
- Agree to continue reassessment and training as an on going hospice function when the training program itself ends.
- Determine the training participants, with the assistance of the trainer.
- Encourage all designated participants to make a commitment to attend all sessions of the training, document compliance (although attendance should be voluntary), and if necessary, arrange for make-up sessions for pivotal team members.
- Allow time for data collection and evaluation activities, including staff interviews and completion of forms (as described in Monograph 3).
- Allow time for staff to participate in the training sessions.
- Arrange for payment of staff for this time, where applicable, negotiating budget reallocations where necessary.
- Arrange for meeting rooms and, if necessary, visual aids or other support materials.
- Recognize that the team and the care may get worse before they get better (especially if changes in organizational structure are involved).
- Provide the time and energy that may be necessary to help staff cope with their intense feelings toward the training.

- Confirm legal liability for unanticipated but possible individual extreme reactions during training (the trainer does not assume this liability).

- Consider the training program as a total entity, and agree not to discontinue it even if either there is a negative reaction to one or more of its parts or it is considered a "waste of time". If unforeseen circumstances should arise that require the termination of the training, negotiate the process and timing of the termination with the trainer.

B. Suggestions from Hospice Training Experience

In preparing for the hospice training, and in particular, in identifying the individual(s) who will conduct the training, the hospice administration should be prepared to confront some obstacles. Hospice training experience has confirmed that the following generic problems can and do arise in hospice training:

- Trainer fails to identify the "real" issues. It should be remembered that some trainers "sell well". They may, in fact, sell so well that the hospice may purchase services of little importance to its problems. For example, a team trainer may have outstanding credentials for organizational work, which may be unrelated to hospice team building. Hospices should be wary of accepting philosophies, skills, and approaches which do not address their particular concerns.

- Trainer promises too much. When the hospice first contacts the trainer to discuss the training program, it may appear to the trainer that the problem is a text book example of a classic problem and is easily resolved. Solutions to many problems may appear easy across a desk when, in reality, they may be beyond the expertise and skill of the trainer. The hospice can assist the trainer in the process of discerning whether or not his or her skills are appropriate for the position by not over simplifying any issues or problems. Time should be invested in preparing for the initial interview with the trainer in order to reflect the hospice's situation most accurately.

- Trainer fails to specify role clearly. Based on previous experience the trainer will have some thoughts about his or her role in the training process. These impressions, when coupled with the training needs of the hospice, should be compared with guidelines provided in this series. Hospices should recognize the trainer's initial limited knowledge of the team and the organization in which it functions.

During negotiations with the trainer, any changes in that role or in the expressed goals of the trainer should be made evident to the hospice management.

- Trainer fails to understand or adapt to uniqueness of hospice's problems. Through his or her involvement with multiple other organizations the trainer has, in all probability, noted patterns in presenting issues and in their manifestations within the organization. This may lead the trainer to view problematic issues as they "typically" are, rather than as they actually are. The hospice can orient the trainer to reality by continually pointing to the uniqueness of the hospice's constraints and problems. A discussion of the resources and limitations (money, staff availability, scheduling), as well as patient and family care goals, may help illustrate this uniqueness.

C. Examples from Hospice Training Experience

During ELM's hospice training experience, a number of potential trainers were interviewed and considered. There were some who were more qualified than others, some whose motives and styles seemed more appropriate than others, and some whose interest in hospices and hospice staff members was considerably greater than others. Those judged either inappropriate or not sufficiently qualified included the following:

- A bright young lecturer in an academic setting who felt he could quite easily find the information he needed in the library and prepare a paper to read to the group.
- A health care trainer who believed her role was to assist individuals in coping with the hostile environment around them and to adapt to their work climate, rather than seeing individuals as being change agents within their groups.
- An experienced trainer who discussed theory in a way that was over the heads of the group members, and appeared unable or unwilling to make the information clear and meaningful to them.
- A health psychologist, experienced in working with terminally ill patients, who saw the impact of groups on people but did not visualize people as the fabric of groups.
- An experienced trainer who had no knowledge of the health care field and who felt there would be no differences between training teams of firemen and teams of hospice caregivers.

- An expert in hospice care who addressed all his remarks to the members of only one of the disciplines represented in the group.

- A nationally known trainer who seemed to be more interested in describing her own success to the group than in assisting the group to become successful.

Such influences have led ELM to conclude than an appropriate trainer needs to be knowledgeable about health care provision the disciplines involved (physicians, nurses, social workers, etc.) and their conventional relationships, to appreciate the inherent stress in their contrasting roles, to understand group process enough to be comfortable performing a facilitative role in groups, and to be sufficiently self assured not to let his or her own ego get in the way of the group's progress. The trainer also needs to understand organization theory and training program design in order to help set up the best "custom-built" program to meet each hospice's needs. The trainer, to be effective, must have positive regard for and build good working relationships with the hospice's management, administration and staff.

Hospices are encouraged to introduce interdisciplinary team training and humanistic patient care training as soon as the prerequisites are met, even though the hospice may already provide humanistic patient care using an interdisciplinary team approach. Hospice experience has shown that when team function has been attempted but only partially implemented, the team approach itself becomes an additional stressor for hospice staff. It has also shown that there appears to be no limit to the improvement possible in humanistic patient care provision. For these reasons, this training program will surely benefit any established hospice, not only through the formal trainer-conducted program but also thereafter as the ongoing reassessment and training continues.

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